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March 22, 2006

VIA Electronic Mail and Hand Delivery
Board of Directors, Dirigo Health Agency
Attn: Lynn Theberge
Dirigo Health Agency
211 Water Street
Augusta, Maine

In Re: Determination of Aggregate Measurable Cost Savings
For The Second Assessment Year (2007)

FILING COVERSHEET

Dear Ms. Theberge:

Enclosed for filing please find the following:

Submitted by: D. Michael Frink

Date Filed: March 22, 2006

Party: Maine Association of Health Plans ("MEAHP")

Document: **Pre-Filed Testimony of Daniel Fishbein, MD**
Pre-Filed Testimony of Jennifer Rottkamp

Document Type: Pre-filed testimony

Confidential: No

Sincerely,

D. Michael Frink

cc: Service List

CERTIFICATE OF SERVICE

I hereby certify that on March 22, 2006, the foregoing documents were served electronically and two copies hand delivered via courier upon:

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Dirigo Health Agency
Attn: Lynn Theberge
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Augusta, Maine
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I hereby certify that on March 22, 2006, the foregoing documents were served electronically and one copy by regular U.S. Mail upon:

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Dated: March 22, 2006

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NON-CONFIDENTIAL

STATE OF MAINE

DIRIGO HEALTH AGENCY

BOARD OF DIRECTORS

IN RE:	)	EXHIBIT ___
	)	
DETERMINATION OF AGGREGATE	)	
MEASURABLE COST SAVINGS FOR	)	PREFILED TESTIMONY OF
THE SECOND ASSESSMENT YEAR	)	DANIEL FISHBEIN, M.D.
(2007)	)	
	)	
	)	
	)	***March 22, 2006***
	)	

I. Introduction and Overview.

Q. Please state your name and your position with Aetna.

A. My name is Daniel R. Fishbein. I am currently the Head of Aetna's national Health Plan Alliances business, and I am based in the company's Portland, Maine office. I can say that, in general, I am very familiar with our products, provider network, and customers in Maine.

Q. For whom are you testifying?

A. Aetna and the Maine Association of Health Plans ("MEAHP").

Q. Have you testified previously in a case involving the establishment of the Dirigo Savings Offset Payment?

A. Yes. I submitted prefiled testimony (and testified) in October of last year in the proceeding before the Superintendent of Insurance of the State of Maine regarding the savings calculation then being sponsored by the Dirigo Health Agency ("DHA"). From what we can tell, the DHA Staff will take a similar approach to making its savings calulation in this case, and therefore I have attached a copy of my October, 2005 prefiled testimony before the Superintendent as Fishbein Exhibit 1 to this testimony. I adopt the testimony in Fishbein Exhibit 1 (with incorporated Exhibits 1(1) and 1(2)) as my testimony in this case. I will provide additional testimony, and updates to my 2005 testimony, in the balance of this testimony.

Q. How did you prepare for your testimony on this occasion?

A. As in 2005, I reviewed Aetna medical costs trends for Maine and the so-called Dirigo law enacted by the Maine Legislature in 2003 (as amended in 2005), and I spoke with Aetna's network operations personnel in Maine to determine whether they have noticed any impact resulting from the various Dirigo initiatives discussed in this case.

Q. Was your preparation in this case any different from your preparation in the 2005 case?

A. Yes. In last year's case before the Superintendent, the DHA's consultants had prepared studies (by Dr. Kane and by the Mercer Group) that offered a detailed explanation of the savings being proposed by the DHA Staff on an item-by-item basis, and the DHA Board largely rested its conclusions on those studies. Obviously we disagreed strongly with what was in those studies, but at least we knew what was being proposed. A critical aspect of my preparation, therefore, was to review the studies -- which were available well in advance of the date when my prefiled testimony was due -- that formed the basis of the Board's proposed savings level. In my testimony, I pointed out areas where we disagreed with the studies and explained the basis for our disagreement.

In this case, by contrast, we have been required to submit testimony before the DHA Staff has provided a complete description of its proposal for determining what aggregate measurable savings should be for Dirigo Year 2, and with only a summary explanation (provided 48 hours before this testimony was due) regarding how it will arrive at whatever savings level it eventually elects to sponsor. (I refer to Mercer's

Report to the DHA regarding its Year 2 Methodology and Data Sources which we received for the first time on March 20th.) I was therefore unable to prepare properly for this testimony, and have had to resort to re-submitting my 2005 testimony with the hope that it may be relevant to whatever the DHA Staff eventually proposes. I understand that I will be given an opportunity to supplement this prefiled testimony when I appear before the Board and have had an opportunity to review both the DHA Staff's testimony and the testimony filed by other parties.

Q. **Do you think that this process will affect the Board's ability to reach a sound decision in this case?**

A. Definitely. All of the non-DHA-Staff witnesses submitting prefiled testimony have had a fairly limited amount of information to work with and a very limited amount of time to digest and consider it. The quality of the non-DHA-Staff testimony has to suffer as a result, and the Board's ability to reach a sound decision will therefore be impaired.

II. The SOP Must Be Limited to Savings Resulting from DHA's Operations.

Q. What is MEAHP's position regarding the calculation of "aggregate measurable savings?"

A. As I discussed in my 2005 testimony, MEAHP takes the position that under the Dirigo law, only savings that result (a) from DHA's "operations," and (b) from the expansion of MaineCare enrollment can be counted. I explained MEAHP's position on this issue at pages 5 through 7 of my 2005 testimony, and we discussed this issue both in

our Brief to the Superintendent and in our Brief to the Court which is reviewing the Superintendent's decision.

Q. How did the Superintendent resolve this issue?

A. He took the position that under the so-called Dirigo Law, his responsibilities were limited to reviewing the *factual* basis for the DHA's decision. He therefore did not reach the legal question we presented regarding whether the DHA could claim savings from any category besides bad debt and charity care and an increase in MaineCare enrollment.

Q. Did the DHA address this issue when it set the Savings Offset Payment in 2005 following the Superintendent's Order?

A. No. The DHA refused to grant an adjudicatory hearing at that time. MEAHP presented this legal argument to the Board, but we got no response. It now has the issue squarely presented in this case, however, and therefore my 2005 testimony is very relevant to one of the major issues before the Board in this case.

Q. Have the State's actions in the area of MaineCare funding in fact had any impact on savings levels?

A. Yes. From what we have been able to determine, the State's handling of its MaineCare program has severely aggravated the cost shift problem, overwhelming any savings that might have resulted from an expansion of MaineCare enrollment and any potential reduction of bad debt and charity care derived from DHA's operations.

Q. Could you please explain this?

A. Yes. On February 14 of this year, the Insurance and Financial Services Committee of the Maine Legislature held a hearing on L.D. 1935, the bill that would prohibit private insurance companies doing business in Maine from including SOP

charges in their insurance rates. In the course of that hearing, the Committee heard testimony from Stephen R. Michaud, President of the Maine Hospital Association ("MHA"), and a representative from Maine Health, which includes Maine Medical Center and a number of other health care facilities in southern Maine. I am attaching their written testimonies, which were submitted to the Committee, as Fishbein Exhibits 2 and 3.

Mr. Michaud's testimony states that MHA's member hospitals have generated savings, but he explains that: "How much of these savings are attributable to Dirigo is impossible to pin down given all the factors that go into hospital budgeting and that is part of the problem with the SOP as currently constructed." Of course, here Mr. Michaud makes exactly the same point made by Mr. Shiels, Mr. Tobin and some of the Anthem witnesses in their testimony in last year's case, and which Ms. Rottkamp of CIGNA makes in her testimony being filed by MEAHP in this case .

Mr. Michaud then points out that "in the very same year Dirigo was passed Medicaid payments to hospitals were cut by nearly $60 million. Obviously the resulting cost shift diminished any savings to premium payors."

The MaineHealth testimony makes the same point, but with a different cost shift number. MaineHealth states that, while Maine hospitals "generated over $44 million in savings, the State reduced its payments to hospitals by over $40 million. These reductions allowed the state to cover budget shortfalls. These reductions also forced hospitals to shift their costs to cover these losses. So while hospitals may have generated savings, insurors did not necessarily realize them. Savings generated by hospitals essentially went to cover the MaineCare deficit."

Q. The MHA Testimony identifies a $60 Million MaineCare budget cut, while MaineHealth identified a $40 Million shortfall. Were you able to reconcile these figures?

A. Yes. We contacted the MHA to go over this and they furnished us with a very useful table, attached as Exhibit Fishbein 4, that provides the background for these numbers. This Table summarizes the MaineCare budget cuts implemented by the Maine Legislature for the 2004-05 biennium. The State of Maine is on a July 1 fiscal year basis, so the middle two columns (labeled "2003-04" and "2004-05") match up exactly with "Dirigo Year One" (July 1, 2003 through June 30 2004) and the period at issue in this case, "Dirigo Year 2" (July 1, 2004-June 30 2005). If you total up the MaineCare cuts, you find that in Dirigo Year One, the Legislature cut MaineCare by $24,503,131, and in Dirigo Year Two it cut MaineCare by $33,683,310, for a total cut during the biennium of $58,186,441. The MHA explained to us that the $40 Million number in the MaineHealth testimony consisted of the $33,683,310 MaineCare budget cut during Dirigo Year Two plus the additional hospital tax imposed by the Legislature that year, for a total of $40 Million. The "nearly $60,000,000" number in Mr. Michaud's testimony was based on the total $58 Million in cuts, rounded up to an even $60 Million.

Q. Didn't the expansion of MaineCare enrollment help provide additional funding to hospitals, thus addressing, at least to some degree, the cost shifting problem?

A. We understand that the expansion of MaineCare enrollment did provide some extra money for Maine hospitals. I notice that the Year 2 Mercer Report, which we received a few days ago, indicates that Mercer plans to include this factor as part of its

overall savings calculation. The point we are making here, however, is that the negative impact of the MaineCare budget cuts totally overwhelmed any positive effect from the MaineCare enrollment expansion. Despite this, based on what we can determine from the Year 2 Mercer Report, DHA intends to ignore the tremendous impact of these cuts, while including as savings some amount from the MaineCare enrollment expansion.

As last month's hospital testimony to the Legislature establishes, (a) the hospitals made up for the MaineCare budget cuts by cost-shifting the additional burden over to the charges levied to their insured patients, and (b) the impact of this cost shift wiped out any savings from the Dirigo initiatives (to say nothing of the relatively meager savings resulting from DHA's insurance operations).

Q. Can you comment on the Health Care Provider Fee Savings Initiatives described in the Year 2 Mercer Report?

A. This portion of the Year 2 Mercer Report basically makes our case. It states that:

> differences between financial requirements and payments by various payers may be shifted to the private sector payers, whose rates are negotiable (unlike the public sector – Medicare and Medicaid – where rates are determined by the public payers), resulting in higher rate increases to private payers. The State will make additional payments to hospitals and physicians as a result of the Dirigo Health Reform Act and its related initiatives. Therefore, the need for cost increases to other payers will be reduced when this additional cash is received by hospitals and physician providers, resulting in a savings to the system.

Year 2 Mercer Report at 5, 27. Of course, it is sheer sophistry to include in a savings calculation a few million dollars in State-initiated savings without offsetting those savings by the amount of a massive state-imposed budget cut on the ground that the cash payments wear the Dirigo "and its related initiatives" label, while the huge budget cut does not.

Q. How should the Board address this issue.

A. Obviously, it would be absurd for the Board to develop a savings calculation that did not reflect the fact that, according to Maine hospital industry representatives, the MaineCare budget cuts have caused Maine hospitals to shift almost $34 Million in costs over to private insurors. I therefore recommend that the Board net any savings number that the DHA Staff proposes against this amount. It should handle any claimed savings from the so-called Physician Fee Initiatives in the same fashion.

III. Impact on Aetna in Maine from DHA Operations.

Q. On page 8 of your 2005 testimony you provided some statistics on Aetna's market position in the Maine health insurance market. Could you restate those statistics and provide any updates?

A. Yes. Aetna still has about 89,500 Maine members in various types of health plan products including HMO and PPO plans. Most of these plans are provided by 3,209 employers to their employees in Maine. Aetna contracts with 39 hospitals in Maine and 2,698 Maine physicians. In 2004, Aetna paid 1,472,000 healthcare claims for Maine residents and paid $186,000,000 for those claims. Aetna collected $195,332,000 in premiums from its Maine operations in 2004. In addition, Aetna has an office in Maine and employs about 300 Maine residents.

Q. In your 2005 testimony, you stated that "Since July of 2003, we have seen a few hospitals temporarily lower their charges. However, Aetna has seen no net reduction in hospital charges either from these particular hospitals, or from Maine hospitals in general." Have you updated this information?

A. Yes, we have updated this data and a representative sample shows that we have not seen any slowing in the rate of increase of hospital costs in Maine. In fact, it appears that the rate of increase has actually accelerated in the most recent period. Based on discussions with hospitals and our own observations, we speculate that this is due to two reasons.

Q. How do you account for this growth in costs?

A. First, only two hospitals appear to have participated in the voluntary cost controls mentioned by Mercer in its Report, and those for only a brief period of time. Second, any increase in MaineCare funding has been more than offset by a combination of the budget cuts I mentioned earlier together with delays in payment to hospitals resulting from the new MaineCare computer system.

As I stated earlier, (a) any additional funding that hospitals may have received has been more than offset, and therefore has been retained by the hospitals, and (b) any realistic calculation of MaineCare-based savings should therefore be a net calculation with the costs associated with (i) the Dirigo Year 2 MaineCare budget cuts, and (ii) the delays in payments included in the calculation.

Q. In your 2005 testimony, at page 10, you discussed the re-negotiation of provider contracts with Maine hospitals and stated that through the end of October of 2005, Aetna had "re-negotiated contracts with 15 of the 39 hospitals in Maine. In

eight of these negotiations, the resulting terms were less favorable than they were in the prior agreement, in three they are better, and in four they stayed about the same." Could you please update this information?

A. In the time I had available to prepare this testimony I was not able to obtain more recent information on our renegotiations. I will continue my efforts with the objective of providing an update when I take the stand in this proceeding.

I would note, as I did in my former testimony, that all of these contracts give the hospitals the ability to increase their underlying charges against which the negotiated discounts are applied.

Q. In 2005, you pointed out that the steep hospital cost increases experienced in Maine ran directly counter to the national trends. Has this changed?

A. I am not aware of any change in the national trend; however, as I stated above health care costs in Maine appear to be accelerating. Thus, the Maine trend is diverging from the national trend at an even greater pace than before.

Q. What conclusion do you draw from this information?

A. I can only reiterate my conclusion from my prior testimony: Maine hospital charges are going up at an ever-increasing rate.

Q. Does this conclude your testimony?

A. Yes, it does.

Fishbein Exhibit 1

NON-CONFIDENTIAL

STATE OF MAINE

DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

BUREAU OF INSURANCE

IN RE:	)	EXHIBIT ___
	)	
REVIEW OF AGGREGATE	)	
MEASURABLE COST SAVINGS	)	PREFILED TESTIMONY OF
DETERMINED BY DIRIGO HEALTH	)	DANIEL FISHBEIN, M.D.
FOR THE FIRST ASSESSMENT	)	
YEAR	)	
	)	
Docket No. INS-05-700	)	***October 21, 2005***
	)	

I. Introduction and Overview.

Q. Please state your name and your position with Aetna.

A. My name is Daniel R. Fishbein. I am currently the Head of Aetna's national Health Plan Alliances business, and I am based in the company's Portland, Maine office. I attach as Fishbein Exhibit 1 a Biosketch that details my background and experience in the healthcare field. I can say that, in general, I am very familiar with our products, provider network, and customers in Maine.

Q. For whom are you testifying?

A. Aetna and the Maine Association of Health Plans ("MEAHP").

Q. What is the Maine Association of Health Plans?

A. The Maine Association of Health Plans is the trade association that represents the administrators of self-funded and fully insured health benefit plans in the State of Maine. The members of the Association are Aetna Health, Inc, Anthem Blue Cross/Blue Shield of Maine, CIGNA HealthCare of Maine, Inc. and Harvard Pilgrim HealthCare. Collectively, health plans under the administration of MEAHP members cover approximately 665,000 Maine people.

Q. How did you prepare for your testimony?

A. I have reviewed various materials related to these proceedings including the Mercer Report, the Lewin Report, Aetna DRG data for Maine, Aetna medical costs trends for Maine, the so-called Dirigo law enacted by the Maine Legislature in 2003 (and amended earlier this year) and draft pre-filed testimony submitted by Anthem Blue Cross/Blue Shield. Also, MEAHP is

sponsoring, with the Maine State Chamber of Commerce, the testimony of Mr. John Shiels of the Lewin Group, and I have reviewed his prefiled testimony. I have also spoken with Aetna's network operations personnel in Maine to determine whether they have noticed any impact resulting from the various Dirigo initiatives discussed in this case.

Q. Please indicate the purpose of your testimony.

A. First, Aetna supports the goals of the so-called Dirigo law in attempting to reduce the number of uninsured and underinsured people in Maine. In addition, Aetna supports the State in any efforts to reduce healthcare costs to employers and individuals in Maine. However, both of these goals cannot always be achieved at the same time and with the same program. Presently, we have not yet experienced actual savings resulting from the operations of the Dirigo Health Agency ("DHA") to pass back to the program. In order for this process to make sense for employers and consumers and to be a sustainable program, we need to be careful to only apply realized savings to fund DHA's insurance operations.

In my testimony, I will discuss MEAHP's position on how the savings should be calculated under the Dirigo law and whether the filing made in this case by the DHA meets the requirement of the law. I will summarize the specific flaws in the DHA savings determination identified by MEAHP, and I will discuss several of these flaws in detail. Another MEAHP witness, David Tobin of CIGNA, will submit testimony from his standpoint as an actuary working in the health insurance field regarding other specific problems with DHA's savings calculation.

In addition I will present information regarding medical costs incurred in Aetna's Maine health plans, medical cost trends in Maine and Aetna's network operations in Maine. Based on this information, I offer my conclusion that Aetna and its customers have not realized any of the hypothetical cost savings as outlined in the Mercer report.

Q. Do you believe that DHA's savings calculation represents a reasonable approach to determining savings?

A. No, I do not. The primary reasons for my conclusion are as follows:

(a) DHA claims credit for savings that, even if they could be measured, were clearly not the result of the *operations* of DHA;

(b) DHA has failed to show that any of the savings that it claims providers have enjoyed have in fact been passed on to health plan administrators in the form of charges that are lower than they would otherwise have been; and

(c) none of these alleged savings have been realized by Aetna or our health plan purchasers (employers and members) in Maine.

Q. What would be the result if the Superintendent establishes a level of aggregate and measurable cost savings in excess of the savings actually realized by the plans due to the operations of DHA?

A. My understanding is that the basis for making a Savings Offset Payment ("SOP") to DHA was that, prior to payment of any SOP assessment, (a) DHA's *operations* would have generated actual savings for providers, and (b) those providers would have actually passed those savings along to the carriers in the form of lower charges covered by the carriers. After all, the purpose of the Savings *Offset* Payment is to offset savings. If the SOP is greater than the actual savings, then the net effect is an *increase* in total costs.

Moreover, as Mr. Tobin of CIGNA, Ms. Roberts of Anthem and Mr. Shiels of the Lewin Group all explain in their testimonies, it is generally accepted in the industry that each increase in health insurance rates causes some percentage of the existing base of insured people to drop or lose coverage. Since carriers have not realized any of these hypothetical DHA-generated savings, approval of DHA's savings calculation means that carriers operating in Maine will be

required to increase premiums in order to reflect an inappropriate SOP. This would undoubtedly result in some Maine people losing their health insurance as a result of DHA.

II. The SOP Must Be Limited to Savings Resulting from DHA's Operations.

Q. What is MEAHP's position regarding the calculation of "aggregate measurable savings?"

A. MEAHP's attorneys have advised us that under the Dirigo law, DHA can only claim savings that result from its "operations," and from the expansion of MaineCare enrollment. They further advise that by "operations," the Legislature meant to capture only the savings passed along to carriers by DHA's insurance offerings. These savings would occur to the degree that DHA's insurance program changed the ratio of uninsured (and under-insured) versus insured patients visiting hospitals and other providers for care. This would theoretically result in a reduction of bad debt and charity care costs incurred by Maine hospitals. If the providers in fact experienced such reductions due to DHA's insurance, and if the providers then passed those reductions along to the plans in the form of lower charges, then one could say that DHA's operations had produced savings, in turn justifying an SOP.

Q. What is your understanding as to what DHA must show in order to sustain its savings calculation?

A. It must establish that Maine health plan administrators have experienced aggregate measurable cost savings passed along to them by healthcare providers who have funded the reduced charges out of reductions in bad debt and charity care-related costs directly resulting from (a) DHA's *operations*—that is, resulting from the healthcare coverage that it offers—and (b) the expansion of MaineCare enrollment. The savings level so established then becomes a cap

on the SOP assessment which DHA may levy. The actual SOP assessment gets determined in a subsequent proceeding before DHA and is supposed to be based on the criteria established in the law, and on certain savings-related reports called for in the law.

In addition, I have reviewed a handout, attached as Fishbein Exhibit 2, distributed by the Governor's Office of Health Policy and Finance dated June 11, 2003. It was distributed at the time of the floor vote in the Legislature on the Dirigo law and it explains the Governor's Dirigo proposal to Maine's Legislators and the public generally. The second page of the handout contains a five-point explanation of how the subsidies built in to DHA's healthcare coverage will be financed. The third and fourth points are consistent with my understanding of what DHA must show:

- Capture realized savings *from the reduction in bad debt and charity care* through savings offset payments by health insurance carriers, third-party administrators, and employee benefit excess insurance carriers. Payments will be made by insurers to Dirigo Health only after savings are shown. Insurers' payments will offset savings so payments will never exceed the savings
- Use the savings offset payments to fund premium subsidies of those with incomes above MaineCare eligibility and below 300% of the federal poverty level after the first year and to fund the Maine Quality Forum

Q. Has DHA limited the scope of its savings calculation to cover only realized savings from the reduction in bad debt and charity care?

A. No. In fact, the only category of savings identified in DHA's September 19 filing that meets this criterion can be found in the "Uninsured/Under-Insured Initiatives" section of DHA's September 19 filing. These savings, as calculated by DHA, amounted to $5.7 Million. Mr. Shiels' testimony discusses the particular problems with DHA's methodology for measuring savings from reductions in bad debt and charity care. Suffice it to say that Aetna has realized

little or no savings from this source. Beyond that, according to DHA's own statistics, only 22% of the 8,000 plus Dirigo members were previously uninsured.

The rest of the savings proposed by DHA have nothing to do with its "operations," and in any event are well outside the bad debt/charity care/MaineCare-enrollment-based savings analysis identified as the source of savings in the material distributed by the Governor's Office that I referred to above. It is MEAHP's position that these other categories of savings should never have been included in DHA's savings calculation, and that the Superintendent should disregard them.

III. Alleged Savings from the "Part F Requests" Should Not Be Included in Any Calculation of Savings Generated by DHA's "Operations".

Q. In the 2003 law that launched DHA, the Legislature asked for a series of voluntary cost and price limits for the Maine healthcare market. Could you comment on these items?

A. Yes. In Section 1 of Part F of the 2003 law, the Maine Legislature asked healthcare practitioners, hospitals and health insurance carriers to adopt certain voluntary limits on cost growth. Section 1 states that the purpose of these requests was "to control the rate of growth of costs of healthcare and health coverage."

Q. What is MEAHP's position on the propriety of DHA's inclusion of supposed savings from these initiatives in the savings calculation?

A. As I stated earlier, MEAHP's attorneys have advised us that the statute that describes the savings from which the SOP is to be determined limits the savings calculation to the savings resulting from DHA's "operations," and that any savings that may have resulted from the

Legislature's request, in 2003, that Maine healthcare providers (and others in the system) limit their charges cannot be included in a calculation of savings resulting from DHA's "operations." Again, this is an issue of statutory construction that I am not qualified to discuss.

IV. Impact on Aetna in Maine from DHA Operations.

Q. What is Aetna's market position in the Maine health insurance market?

A. Aetna has 89,520 members in various types of health plan products including HMO and PPO plans. Most of these plans are provided by 3,209 employers to their employees in Maine. Aetna contracts with 39 hospitals in Maine and 2,698 Maine physicians. Last year, Aetna processed ___ healthcare claims for Maine residents and paid _____for those claims. Aetna collected $195,332,000 in premiums from its Maine operations in 2004. In addition, Aetna has an office in Maine and employs 202 Maine residents.

Q. Have you reviewed Mr. McCormack's testimony regarding the process of hospital negations in Maine?

A. Yes.

Q. Do you agree with his conclusions regarding the difficulty of reducing or limiting hospital rate increases in a contract negotiation?

A. Yes

Q. Have you reviewed Mr. McCormack's testimony regarding the process of negotiations with physicians in Maine?

A. Yes.

Q. Do you generally agree with his conclusions?

A. Yes.

Q. In his testimony, Mr. McCormack states that Anthem enters into multi-year agreements with providers that affect the flow-through of cost savings to plans. Do you agree with this point?

A. To some extent. Since negotiations do not occur annually but instead take place every few years, we do not have an annual negotiation process where we try to obtain additional negotiated discounts with providers including any alleged savings generated by Dirigo. Even if we did have an annual negotiation, however, I do not think it would make much difference in our ability to obtain savings from hospitals based upon alleged savings generated by Dirigo.

Q. Why is that?

A. As Mr. McCormack and Mr. Keane explain in their testimonies, Maine plans almost universally negotiate percentage-of-charges contracts with hospitals. This results in negotiated payments for provider services generally being below providers' usual and customary charges and rates. If a hospital would have set its charges at "Level X," but instead sets its charges at Level X minus 5% as a result of DHA's operations, then the reduction in charges (and the commencement of savings) would be effective as of the date that the new, lower charges went into effect (not when the agreement is renegotiated). This is the point that Mr. McCormack makes in his testimony when he states that percentage of charge contracts (which he refers to as "discount off charge" contracts) only yield savings when the hospitals in fact lower their charges.

Since July of 2003, we have seen a few hospitals temporarily lower their charges. However, Aetna has seen no net reduction in hospital charges either from these particular hospitals, or from Maine hospitals in general.

Mr. Keane's data shows that in fact Maine's hospitals are increasing their prices at a rate that substantially outstrips the cost increases they are experiencing—a point that renders DHA's hospital-cost-based approach to determining savings invalid per se.

Q. Are there any regulatory constraints that MEAHP members have encountered in seeking favorable arrangements with Maine hospitals?

A. Yes. In Maine, the requirements of Rule 850 obligate health plans to include virtually all hospitals, doctors and other providers in their networks, which largely eliminates the ability of health plans to exert any leverage in these negotiations.

Q. Can you indicate whether Aetna has made progress recently in its negotiations with Maine hospitals?

A. While we do not re-negotiate provider contracts with each Maine hospital every year, there have been a substantial number of renegotiations so far in the first ten months of this year. So far this year we have re-negotiated contracts with 15 of the 39 hospitals in Maine. In eight of these negotiations, the resulting terms were less favorable than they were in the prior agreement, in three they are better, and in four they stayed about the same.

In addition, as I mentioned previously, all of these contracts give the hospitals the ability to increase their underlying charges against which the negotiated discounts are applied.

Q. Have any of the hospitals in your network increased their charges?

A. In virtually all of our hospital relationships, the hospitals have increased their underlying charges this year.

Q. What are Aetna's overall medical cost trends in Maine since the first quarter 2004?

A. Overall, Aetna's net medical cost trends in the first quarter 2004 were 7% above the first quarter in 2003. The latest quarter for which data is available, the third quarter of 2005, has a net trend of 9% above the third quarter in 2004. Aetna and its customers have not seen any reduction in its medical cost trends since 2004 and its most recent trend does not indicate any reduction in medical cost for Maine residents. Based upon this information Aetna has not realized any of the assumed, hypothetical savings submitted by the DHA and in fact medical cost trends are increasing year to year.

Q. Have Aetna's hospital costs gone up in Maine in the last year?

A. Aetna's hospital costs on both a per-day and per-admit basis for the 6/30/2004 to 7/1/2005 ("2004-05 time period") time period showed a substantial increase over the costs observed in the previous twelve-month period (from 6/30/2003 to 7/1/2004, "2003-04 time period"). On a per-admit basis, hospital costs for the top 25 DRGs in Maine increased 8.8% from 2003-04 time period to the 2004-05 time period. The same top 25 DRGs increased 5.4% on a per-admit basis from 6/30/2002 to 7/1/2003 ("2002-03 time period") to 2003-04 time period. Therefore, not only have the costs increased but also the rate of increase has gone up, not down in the last year. In addition, Aetna has seen an upward trend in amounts incurred for the top 25 DRGs on a per day basis. The 2004-05 time period per day paid amounts were 10.2% above the same DRGs for 2003-04 time period. This is more than the 7.1% increase sustained from 2002-03 time period to 2003-04 time period.

Q. How does this compare with the national trend?

A. If you refer to Tobin Exhibit 1, attached to Mr. Tobin's testimony, you will see that the trend has been moving in just the opposite direction on a national basis.

Q. What conclusion do you draw from this information?

A. Not only have hospital costs gone up in Maine in the last year on both a per-admit and a per-day basis, but the rate of increase is higher than in the previous period.

Q. Does this conclude your testimony?

A. Yes, it does.

Fishbein Exhibit 1(1)

Biosketch of Daniel Fishbein, M.D.

Dan is Head of Aetna's national Health Plan Alliances business, and is based in the company's Portland, Maine office. Health Plan Alliances consists of various businesses that provide services to other health plans and includes HMS Healthcare of which Dan is President. HMS Healthcare provides network and medical management services in Michigan, Colorado, and several other states and includes the PPOM and Sloans Lake managed-care subsidiaries. Health Plan Alliances also includes the Aetna Signature Administrators business which provides services to large Third Party Administrators. Dan is also responsible for the company's Student Health business which provides college sponsored health plans to more than 120 colleges and universities across the country and currently serves 365,000 students. The Student Health business is operated through The Chickering Group which is the largest provider of Student Health plans in the country and is based in Cambridge, MA. Dan is the President of The Chickering Group.

Previously, Dan was also responsible for Product Development for the Key Accounts segment across the country. In 2002, Dan led the Select and Key Accounts business segment in New England and Upstate New York, with overall business responsibility for the middle market (employers from 50 to 3,000 workers) in Massachusetts, Connecticut, Maine, New Hampshire, Rhode Island, Vermont and Upstate New York. Dan was also a member of Aetna's National Strategy Council, under the direction of the Office of the Chairman.

From 1998 to 2001, Dan was General Manager and had overall responsibility for business in Maine. This included over 100,000 health plan members. During 2001, Dan was part of a six-person team that developed the strategy for the "New Aetna". From 1995 to 1998, Dan was president and CEO of NYLCare Health Plans of Maine, and the regional executive responsible for NYLCare's New England region. NYLCare of Maine was a start-up health plan that grew rapidly from inception to 60,000 members and was a part of New York Life's NYLCare Health Plans subsidiary. Aetna purchased NYLCare in 1998.

From 1990 to 1995, Dan was Vice President and an executive officer of New York Life, responsible for the Product Development and Managed Care divisions of Group Benefits. From 1985 to 1990, Dan was with the Massachusetts Mutual Life Insurance Company in Springfield, MA where he held several positions, including Second Vice President, healthcare product development and managed care.

Dan received his B.A. degree magna cum laude and his M.D. from Boston University.

6/11/2003

Dirigo Health

Dirigo Health will make quality, affordable health care available to every Maine citizen and initiate new and important processes for cost containment and quality improvement.

Access

- Dirigo Health offers Dirigo Health Insurance through private insurance carriers to individuals, small business (<50 employees) and the self-employed – enrollees benefit from lower and more stable rates provided by participation in a larger group
- Universal access to affordable and quality health care is achieved in 5 years
  - MaineCare is expanded to cover more low income citizens: to 125% FPL for individuals and 200% FPL for adults with MaineCare eligible children
  - Individuals, families, small business employees and the self-employed with incomes below 300% FPL are eligible for subsidies to help pay Dirigo Health Insurance premium costs on a sliding scale based on ability to pay – up to $27,000 in income for an individual and $55,000 for a family of 4 (see attachment for Access narrative)

Quality Improvement

- Maine Quality Forum is established – a quality watchdog for Maine providing more public information about costs and quality of health care
  - MQF will collect and disseminate research, adopt quality and performance measurers, issue quality reports, promote evidence based medicine and best practices, encourage adoption of electronic technology, make recommendations to the State Health Plan

Cost Containment

- Commission to Study Maine's Hospitals
  - Examine hospital costs and expenditures, impact on local economies, opportunities for hospital coordination in health care delivery and efficiency, improve planning for capital improvements, etc.

Governor's Office of Health Policy and Finance
15 State House Station, August, ME 04333-0015
Ph: 624-7442 * Fax: 624-7608
GOHPF@maine.gov

- Biennial State Health Plan to assess need and available resources, set statewide goals for health care access and establish a budget for planning statewide expenditures
- One year voluntary caps on cost and operating margin of insurers, hospitals and providers to inform State Health Plan
- Capital Investment Fund is created to place capital expenditures on a budget – ensures wise and appropriate allocation of resources but ends the medical arms race
    - One year CON moratorium (from May 5, 2003) to inform Capital Investment Fund planning
    - Expand CON to ambulatory surgery centers and doctors offices for investments in new technologies costing over $1.2 million and capital expenditures over $2.4 million
- Require small group health plans to submit rate filings to the Superintendent of Insurance for review and approval and strengthened oversight of the large group market

Financing

- Drawdown additional federal Medicaid dollars by expanding Medicaid eligibility
- Use the employers' share of Dirigo health insurance premiums for Medicaid eligible individuals to pay state share of Medicaid expansion
- Capture realized savings from the reduction in bad debt and charity care through savings offset payments by health insurance carriers, third-party administrators, and employee benefit excess insurance carriers. Payments will be made by insurers to Dirigo Health only after savings are shown. Insurers' payments will offset savings so payments will never exceed the savings
- Use the savings offset payments to fund premium subsidies of those with incomes above MaineCare eligibility and below 300% of the federal poverty level after the first year and to fund the Maine Quality Forum
- Use about $52 million one time federal fiscal relief monies to fund the first year premium subsidies and about $1 million to fund the Maine Quality Forum

Governor's Office of Health Policy and Finance
15 State House Station, August, ME 04333-0015
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Fishbein Exhibit 2

MEMORANDUM

TO: Senator Nancy Sullivan, Chair
Representative Anne Perry, Chair
Members of the Insurance & Financial Services Committee

FROM: Steven R. Michaud, President

DATE: February 14, 2006

RE: Testimony in Opposition to LD 1935 - An Act to Protect Health Insurance Consumers

Good afternoon, my name is Steven Michaud and I am the President of the Maine Hospital Association. The Maine Hospital Association represents 39 acute care and specialty hospitals and their affiliates. Our acute care hospitals are nonprofit, community-governed organizations with more than 800 volunteer community leaders serving on their boards of trustees. Maine is one of only a handful of states in which all of its acute care hospitals are nonprofit. In addition to acute care hospital facilities, our hospitals own 19 home health agencies, 19 skilled nursing facilities, 17 nursing facilities, 8 residential care facilities, and 50 physician practices. Our membership also includes the state's two private psychiatric hospitals and a free-standing rehabilitation hospital.

With more than 25,000 full and part-time employees, hospitals are vital to our economy, and as a whole, one of the very largest employers in Maine. Hospitals are most often the largest employer in their communities.

Given that hospitals are such large employers, providers of health insurance for their employees, and thus a significant payor of the Savings Offset Payment (SOP)--$5-6 million, one may wonder why MHA would oppose a bill that would in theory save us millions of dollars. We do not do so lightly.

We support the goals of Dirigo Health and have long supported efforts to expand affordable health care coverage to Maine citizens. We have also worked diligently and successfully to meet our voluntary targets for cost containment as well as quality improvement efforts. In fact, hospitals were responsible for almost all the savings related to the SOP as determined by the Superintendent of Insurance.

Our opposition to LD 1935 is in no way opposition to the goals of Dirigo nor health care reform in general. We do believe however that Dirigo is in need of urgent reform itself and LD 1935 points us in the opposite direction from that reform.

We also believe there have been savings related to Dirigo, while the amount of those savings is not exactly clear. We know it is no where near the more than $200 million originally claimed

during the SOP proceedings last fall, but we believe there have been health care cost savings in the tens of millions of dollars. How much of these savings are attributable to Dirigo is impossible to pin down given all the factors that go into hospital budgeting and that is part of the problem with the SOP as currently constructed. However, there were savings at some amount and they have been passed on by the hospital community to the insurance carriers and self-insured businesses and individuals. It is also important to remember, however, that the very same year Dirigo was passed Medicaid payments to hospitals were cut by nearly $60 million. Obviously the resulting cost shift diminished any savings to premium payors.

Our opposition to LD 1935 is based on the following:

- Any savings that have been reflected in the slowing of the rate of growth in hospital costs and charges have been passed on to the payors and in turn reflected in the lowering of the increase in insurance premiums at the time of renewal.
- To now prohibit a premium tax later assessed from being passed on to premium payors amounts to double taxation. This increases health care costs, it doesn't lower them.
- The original agreement among all parties, and passed on a bipartisan basis, clearly allowed the payors to pass the premium tax on to premium payors. It was clear in the negotiation and is clear in documents from those discussions. This bill is a reversal and a breach of faith to the spirit and the letter of that agreement.
- Passing this bill is not the answer to Dirigo's ills. Passing the bill is worse than putting a band-aid on a patient's gaping wound. It is more like using a band-aid when the patient is suffering from internal bleeding.
- Passing this bill hinders and does not help to fix what is needed if Dirigo or any health care reform is to be successful.
- If Dirigo and health care reform in Maine is to be successful in substantially decreasing the numbers of uninsured by providing coverage and affordable care we must do the following:

  o Acknowledge Dirigo's strengths and weaknesses;
  o Be honest and realistic about Maine's ability to cover all its citizens with health insurance;
  o Be open and honest in budgeting;
  o Reform the health insurance product and its financing;
  o Right size the Medicaid program. Maine is struggling and failing to afford its Medicaid program-a program that is funded 2/3rds by the federal government. How are we to believe that we can afford a large scale effort to provide universal coverage in light of that fact?

As Dana Connors has said, we have established a working group with the Chamber and the payors to make recommendations on restructuring Dirigo and fixing the flawed financing mechanism. We take this effort seriously and are committed to making health care reform work for Maine through that process in partnership with the Legislature and the Governor.

Thank you

Fishbein Exhibit 3

MaineHealth
465 Congress Street • Suite 600 • Portland, ME 04101-3537
(207) 775-7001 • *fax* (207) 775-7029

Testimony of MaineHealth

In opposition to

LD 1935, 'An Act to Protect Health Insurance Consumers'

February 14, 2006

Good afternoon Senator Sullivan, Representative Perry and members of the Insurance and Financial Services Committee, I am here today on behalf of MaineHealth. MaineHealth is a non-profit health care system serving Southern, Central and Western Maine. As Maine's largest health care system, we are committed to the improvement of health care and the health of our communities.

I am here today to testify in opposition to LD 1935, 'An Act to Protect Health Insurance Consumers'. As the debate over the future of Dirigo Health becomes increasingly polarized, it is increasingly difficult to offer constructive criticism. The message from Dirigo proponents and this Administration seems to be all or nothing: you either support every aspect of the Dirigo program or you are opposed to helping people get needed medical care. This message is neither accurate nor helpful. Whether or not there is room in this debate for constructive change will largely be up to this committee and the Legislature. We sincerely hope that this is possible. Because there are aspects of this program that do require reconsideration but that also need broad support, this all or nothing message may, in fact, leave us with nothing.

MaineHealth continues to support Dirigo Health. But we are here again to express our concerns about this particular legislation, while still maintaining our support for Dirigo and its goals. We understand the pressing need to find a way to provide care to the uninsured – we face this on a daily basis. We also understand the need to reduce the

growth of health care costs. We understand this so well, in fact, that we proposed voluntary limits on hospital margins before Dirigo ever existed. We also fully understand the need to find a sustainable funding source if the Dirigo program is going to continue. We are happy to contribute to that solution. Unfortunately, we do not believe this bill represents that solution.

You may wonder why we are even here today, why a hospital system would weigh in on something that 'isn't our fight' since this really impacts insurers. We are here in part because we believe there must be a collaborative – not divisive – approach to solving these complex public policy issues. But, put most simply, this bill is bad public policy and we oppose it as such.

Our reasons for opposing this bill are as follows:

1. This bill presumes that there are savings in the system that insurers are not 'passing on' to employers. It is our belief that any savings that Anthem and other payors did experience have been incorporated into their rates. The Superintendent of Insurance, in his recent ruling on Anthem's rate filing, ruled that Anthem had already included all savings in their proposed rates. The ruling reads, 'The Superintendent concludes that Anthem has made best efforts to ensure recovery of the savings offset payment through negotiated reimbursement rates with health care providers that reflect the health care providers' savings as a result of Dirigo health care initiatives. Therefore, Anthem may include a charge in its rates for the actual savings offset payment'.[1] We have no reason to believe that Anthem or any other insurer has experienced savings that are not included in their rate projections.

2. This bill fails to acknowledge the impact of MaineCare cuts on hospital charges. What this committee may not realize is that at the same time hospitals reduced

[1] State of Maine, Department of Professional and Financial Regulation, Bureau of Insurance. 'Anthem Blue Cross and Blue Shield 2006 Individual Rate Filing for Healthchoice and Healthchoice Standard and Basic Products: Decision and Order', Docket No. INS-05-820

their expense increases and generated over $33 million in savings, the State reduced its payments to hospitals by over $40 million. These reductions allowed the state to cover budget shortfalls. These reductions also forced hospitals to shift their costs to cover these losses. So while hospitals may have generated savings, insurers did not necessarily realize them. Savings generated by hospitals essentially went to cover the MaineCare deficit.

3. There is little meaningful difference between how Anthem and other insurers determine their rates and how self insured companies like MaineHealth calculate their own. To the extent that there were savings in the market – through voluntary limits and reduced operating margins – our health plan experienced those benefits in 2004 and 2005 through claims expenses that were lower than they would have been without the voluntary limits in place. Our projections for 2006 include this history of lower claims, but must also include the assessment for the Savings Offset Payment. In order to cover the full costs of our health insurance plan, we must be able to include these new costs regardless of their source. Insurers, like self-insured employers, must be able to include new costs in their rates in order to accurately project costs of coverage.

4. We are concerned that not allowing insurers to include the assessment in their rates will result in a further reduction in the number of insurers in Maine's insurance market. This will further decrease competition which could potentially result in higher rates for insurance coverage. We think that this should be a concern for everyone.

It is our view that the Savings Offset Payment is a fatally flawed funding mechanism. What were good ideas -- capturing bad debt and charity care costs and limiting rates of increase – have proven inadequate as a funding mechanism for the entire Dirigo Health program. It is not unusual for an ambitious new program to require adjustments and corrections as it is implemented. There were no guarantees that this plan would work. But now that things aren't working out as hoped, the response is not one of coming back to

the table, but one of berating partners for their best efforts. That will guarantee only one outcome - failure.

Health care financing is exceedingly complex and we appreciate the frustration of those trying to change the system. We can make this work. But only if we acknowledge the difficulties – planned and unplanned – and get everyone back to the table for a collaborative solution. The proposal in the bill before you today will make that all but impossible. We urge you to vote against it.

Fishbein Exhibit 4

Hospital Reductions in 04-05
Biennial Budget – Public Law 20
January 14, 2004

	2003-04	2004-05	Biennium Totals
COLA/Inpatient Cuts/No PIP, page 242			
Provides for the reduction of funds resulting from eliminating the Cost of Living Adjustment (COLA) for hospitals. Establishes price per discharge system based upon rebased amount. Rebased amount will be discounted by $8.5 million (state and federal).			
GENERAL FUND	(2,724,246)	(5,302,997)	
FEDERAL EXPENDITURES FUND	(5,472,623)	(10,628,062)	
TOTAL	(8,196,869)	(15,931,059)	(24,127,928)
Outpatient Cuts, page 244			
Provides for the reduction of funds resulting from changing the way that some hospital outpatient services are reimbursed. Limits the percentage of hospital outpatient charges to 75% of charges.			
GENERAL FUND	(3,500,000)	(4,000,000)	
FEDERAL EXPENDITURES FUND	(6,813,076)	(7,768,167)	
TOTAL	(10,313,076)	(11,768,167)	(22,081,243)
Bonus Payments, page 244-245			
Provides for the reduction of funds resulting from eliminating the bonus payment that presently allows a hospital to receive an additional payment when their actual costs are below or significantly above its per discharge payment.			
GENERAL FUND	(2,000,000)	(2,000,000)	
FEDERAL EXPENDITURES FUND	(3,893,186)	(3,884,084)	
TOTAL	(5,893,186)	(5,884,084)	(11,777,270)
Licensure Fee Revisions, page 318			
Hospital Licensing Fees will increase from $10 per bed to $40 per bed.	(100,000)	(100,000)	(200,000)
			(58,186,441)

Prepared by Maine Hospital Association

NON-CONFIDENTIAL

STATE OF MAINE

DIRIGO HEALTH AGENCY

BOARD OF DIRECTORS

IN RE:	)	EXHIBIT ___
	)	
DETERMINATION OF AGGREGATE	)	
MEASURABLE COST SAVINGS FOR	)	PREFILED TESTIMONY OF
THE SECOND ASSESSMENT YEAR	)	JENNIFER D. ROTTKAMP, FSA, MAAA
(2007)	)	
	)	***March 22, 2006***
	)	
	)	
	)	

I. Introduction and Overview.

Q. Please state your name and your position and describe your background and qualifications.

A. My name is Jennifer Dolphin Rottkamp and I am employed by CIGNA Healthcare in Bloomfield, Connecticut where I am an Actuarial Director. In this position, I am responsible for medical pricing in the Northeast of plans for employers with more than 50 subscribers. (This includes those CIGNA plans in Maine that fall into this category.) I hold a Bachelor of Science degree in Business Administration (with an Actuarial Science concentration) from the University of Nebraska – Lincoln and have been employed as an actuary for over nine years. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I live in North Granby, Connecticut.

Q. Who is sponsoring your testimony?

A. CIGNA and the Maine Association of Health Plans ("MEAHP").

Q. How did you prepare for your testimony?

A. I reviewed the October, 2005 Order issued by the Superintendent of Insurance in the aggregate measurable cost savings case that he decided last year (Docket No. INS-05-700), the prefiled testimonies of Dr. Fishbein of Aetna and my colleague at CIGNA, Mr. Tobin, submitted by the Maine Association of Health Plans ("MEAHP") in that case, John Shiels' and Jack Keane's prefiled direct testimony in that case, and various materials related to the current proceedings including Mercer's Report to the Dirigo Health Agency ("DHA") regarding its Year 2 Methodology and Data Sources which we

received on March 20th (the "Mercer Year 2 Report"). I am also specifically familiar with provider cost data and medical cost trends for Maine, and have relied on that knowledge in preparing this testimony.

Q. Do you intend to prepare further prior to taking the stand in this case?

A. Yes. Specifically, I intend to review the prefiled testimony that will be filed by all of the parties, especially DHA. The DHA tstimony should contain a complete explanation of the DHA Staff's proposed aggregate measurable savings for the period in question in this case. Having only a summary of the DHA Staff's proposal for aggregate measurable savings in so-called Dirigo Year 2 has made it impossible for me to prepare this prefiled testimony properly. I therefore plan to update this testimony when I take the witness stand so as to respond as appropriate to whatever DHA and others might submit.

Q. Does the process implemented in this case give you any concerns regarding the Board's ability to reach a sound and well-reasoned decision?

A. Yes. The non-DHA witnesses have been given 48 hours prior to the filing of this testimony to review a sumary of the DHA Staff's proposed methodology and include any resulting comments in this prefiled. Thereafter, we will have less than a week to review the prefiled testimony submitted by DHA Staff and others and prepare detailed comments to be provided to the Board on the stand during the March 28-29 hearings. The board will then have two business days to make a final decision in this case prior to the statutory deadline. (By contrast, I understand that in the 2005 case covering Dirigo Year 1, the participants had the studies provided by Dr. Kane and the Mercer Group will in advance of the hearing before the Superintendent.)

MEAHP is concerned that the rushed schedule and the consequent severe limitation on the time available for a careful review of DHA Staff's proposed savings calculation impairs the ability of the non-DHA Staff parties to prepare an adequate critique of the Staff's proposal. The DHA Board will therefore not have the benefit of the kind of careful review that is needed in this very complex area. This is especially regrettable when one considers that the DHA Staff has submitted a savings calculation methodology which could pave the way for a multi-million-dollar increase in health insurance premiums in Maine.

Q. Please indicate the purpose of your testimony.

A. Because the DHA Staff's March 20 submission is only a summary of its proposal, it is not possible to provide a comprehensive critique at this time. From what I can tell, DHA Staff will be using many of the same methodologies for determining aggregate measurable savings as put forward by DHA for Dirigo Year 1. I have therefore attached (as Exhibit Rottkamp 1) the prefiled testimony submitted by my colleague at CIGNA, Mr. David Tobin, in last year's case before the Bureau of Insurance, since I consider it likely that many of the general points made by Mr. Tobin in his prefiled testimony will again be applicable in this year's proceeding.

Accordingly, I hereby adopt Mr. Tobin's testimony as my testimony in this proceeding. My credentials and position with CIGNA are about the same as Mr. Tobin's, and I have access to, and familiarity with, the same factual data that he presented. I therefore believe I am qualified to offer the same data and opinions that he offered in his 2005 testimony. (Of course, given the requirement for simultaneous prefiling in this case, I cannot be sure whether all of Mr. Tobin's testimony will be responsive to

whatever the DHA Staff ultimately files. I plan to address this issue in further detail when given the opportunity to do so on the witness stand in this case.)

In his testimony, Mr. Tobin explained that the savings claimed by DHA in last year's case were illusory in that (a) they could not be separated from national and local medical cost trends, and (b) DHA admitted that it could not show that the savings calculation that it put forward in fact captured only those savings attributable to DHA (if any), as the law appears to require. He also testified that factors such as utilization trends and the underwriting cycle could have a greater impact than any conceivable impact resulting from DHA's operations. Finally, he explained that any assessment on Maine's private health insurance carriers resulting from the levying of an SOP would have to be passed on to our subscribers in the form of higher health insurance premiums, in turn increasing the number of uninsured Maine citizens.

In his 2005 testimony, Mr. Tobin criticized DHA's approach to determining savings resulting from so-called hospital initiatives on the basis that DHA's exclusion of unfavorable data did not meet the law's requirement that the SOP be based on *aggregate,* measurable savings. The Mercer Year 2 Report appears to indicate that DHA will abandon this approach, and will instead be using state-wide aggregate hospital cost data. This would appear to be consistent with last year's Bureau of Insurance decision, which rejected the selective approach used by DHS in that case. If DHA Staff's testimony adopts the aggregate methodology as apparently described in the Mercer Year 2 Report, then the portion of Mr. Tobin's testimony on this subject can be disregarded, as DHA will essentially have conceded the point.

II. Identifying DHA's Impact on Maine Medical Cost Trends.

Q. In his 2005 testimony, Mr. Tobin offered the conclusion that it would not be possible to objectively determine the impact of the operations of DHA on medical costs in Maine. In the course of his discussion, he provided nationwide data on medical cost trends. Do you have any updates to the information that he provided?

A. Before I respond, I do want to specifically and emphatically state that I completely agree with Mr. Tobin's conclusion regarding the impossibility of making a discrete determination of savings resulting from the reduction of bad debt and charity care costs, plus the expansion of MaineCare enrollment, on state-wide medical care costs. There are simply too many factors that influence the cost of medical care to be able to segregate one factor and objectively determine its impact.

Attached to Mr. Tobin's testimony as Tobin Exhibit 1 is a chart prepared by CitiGroup for its 2006 Health Benefits Survey, which was released on October 11, 2005. (CitiGroup has not yet updated this chart, so it remains the most current version.) I agree with Mr. Tobin's point that any study undertaken for the purpose of identifying the influence of a single factor (here, DHA's operations) on overall healthcare spending would have to carefully control for, and thus take into account, this general trend as well as the numerous other variables that influence hospital charges.

Q. Looking at the Year 2 Mercer Report, can you state whether in fact Mercer proposes to control for this trend?

A. I see nothing in the Report that proposes to control for national trends. Mercer appears to be continuing its prior practice of ascribing all of the savings it finds to the

"Dirigo initiatives," which is clearly inappropriate for the reasons Mr. Tobin (and others) explained.

Q. Could you please comment on the inclusion of the so-called "Hospital Initiatives" in the calculation of the SOP?

A. MEAHP's attorneys have again advised us that under the Dirigo Law, the savings calculation that establishes the ceiling for the Savings offset payment ("SOP") is supposed to reflect only savings from the reduction of bad debt and charity care caused by the operations of Dirigo, and the savings resulting from an expansion of MaineCare. If this legal conclusion is correct, then the Hospital Initiatives may not be considered.

Q. Did CIGNA in fact observe any reductions in charges imposed by hospitals during Dirigo Year 2, the 2004-2005 "savings year" currently under review?

A. We noticed a slight easing of cost increases from Maine hospitals during this period. It is not clear whether (and to what degree) these mild trend reductions were the result of DHA's operations or a result of some of the other dynamics I previously discussed. If DHA-generated savings did in fact occur, the hospitals do not appear to have passed more than a small portion of them on to us. In fact, the hospitals continue to advise our provider contracting staff that their savings resulting from reduced bad debt and charity care have been largely offset by expansions in MaineCare.

Q. In his testimony, Mr. Tobin explained why the additional costs resulting from the expansion of MaineCare have tended to offset bad debt and charity care cost savings. Do you agree with his explanation, and do you have any updates on this issue?

A. Yes, on both counts. I agree with Mr. Tobin that MaineCare does not pay the full cost of the care being provided, producing the "cost shift" to commercial payors (such as my company) and their subscribers. Furthermore, I understand that Aetna/MEAHP Witness Daniel Fishbein will be presenting testimony demonstrating that Maine cut the MaineCare budget in this State by over $33 Million for the time period comprising Dirigo Year 2, greatly aggravating the cost shift from that quarter. This would have greatly reduced the Maine providers' ability to pass on any savings generated by DHA's operations, since $33 Million of costs had to be shifted onto charges covered by Maine's private insurers (and, ultimately, those paying the premiums).

Q. In his Testimony last year, Mr. Tobin explained that hospital prices account for only about one quarter of the total costs covered by health insurers, and that better utilization needs to be pursued as a means of controlling hospital costs. Do you agree with that testimony, and can you provide any updates on what CIGNA is doing to promote better utilization?

A. I agree completely with Mr. Tobin's discussion of this issue, and can confirm that CIGNA continues to pursue a wide variety of initiatives for controlling health care costs. Mr. Tobin mentioned CIGNA's disease management and wellness programs, offering one of our weight management and smoking cessation programs as an example. CIGNA has also pursued so-called "consumer-driven" health plans as an additional vehicle for controlling costs. Attached to this testimony as Exhibit Rottkamp 2 is a February 2, 2006 News Release describing an analysis CIGNA recently completed on this issue. The study determined that the 42,200 members of consumer-driven health plans incurred twelve

percent lower medical costs than the 142,000 members enrolled in non-consumer-driven health plans, while engaging in healthier behavior and using medications more wisely.

Q. How would such savings be treated under the Mercer/DHA Staff approach to determining Dirigo-generated savings?

A. In their construct, all determined savings are ascribed to Dirigo. This means that savings actually generated by these initiatives would be wiped out by the SOP a year or so after the savings are realized. It goes without saying that such an approach totally destroys any incentive for insurers to pursue these programs.

Q. The CMAD measure that Mercer proposes to use to calculate savings again equates hospital expenses with hospital charges. Is this an appropriate assumption?

No. As Mr. Tobin discussed in his testimony, hospital revenues have tended to accelerate faster than hospital expenses, rendering DHA's hospital-expense-based CMAD calculation meaningless for the purpose of determining whether carriers have seen any savings (whether generated by DHA's operations or not). As in last year's case, Mercer proposes to predicate its savings calculation on the assumption that hospital costs and hospital charges have a one-to-one correlation, when in fact no such correlation exists.

The $33 Million cut imposed by the State of Maine on the MaineCare budget for Dirigo Year 2 serves to illustrate this point. Let's take a simplistic example to see how this works. Assume that Maine's hospitals had in fact realized $15 Million in savings during Dirigo Year 2 as a result of reductions in bad debt and charity care resulting from DHA's insurance operations. If the only other change in the mix of factors that together influenced Maine hospital finances during Dirigo Year 2 was the $33 Million cut in the

State's share of MaineCare, then obviously Maine hospitals would have had to increase charges to private insurers by $18 Million to maintain their financial position, net of the Medicare cut. Mercer's approach, however, of ignoring charges and focusing on costs would "find" $15 Million in "savings." If the Board went on to set the SOP at a level equal to the savings as determined in this construct by Mercer, then people paying premiums to private insurers would shoulder *both* a $15 Million SOP *plus* another $18 Million in increased hospital charges resulting from the MaineCare budget cut.

By the way, this example also illustrates the flaw in the Mercer/DHA Staff argument that Maine's private insurers should be aggressively bargaining to obtain the savings as identified by Mercer. A hospital that has sustained, say, $3 Million in Medicare cuts cannot adjust its charges downward to reflect a $1 Million savings in bad debt and charity care costs. Instead, it has to adjust its charges to private insurers *upward* by $2 Million to recover from the cuts, yet the Mercer/DHA Staff analysis utterly ignores this effect.

As Mr. Tobin explained last year, CIGNA, Anthem and the other MEAHP members are almost universally on a percentage-of-charge basis with Maine hospitals. When hospitals see a shortfall in the offing, whether as a result of national cost trends, Medicare budget cuts or any other factor or factors, they increase their revenues by increasing their charges for patients covered by private insurance, and, as I have just demonstrated, this can happen *even if a hospital's actual costs of service are declining.* Therefore, since there is no data demonstrating that hospitals flow through expense savings by adjusting their charges accordingly, hospital cost "savings" identified through the CMAD technique, as developed by Mercer, should be disregarded.

III. The "Carrier Initiative."

Q. In his testimony, Mr. Tobin explained why he considered it illogical and against public policy to include alleged savings resulting from a carrier's voluntary restraint on underwriting gain ("VUG") in the savings calculation. Do you agree with him on this issue?

A. Yes, I do. Also, I note that the Superintendent of Insurance rejected DHA's proposed Dirigo Year 1 VUG savings calculation as not being "reasonably supported by the evidence."

I was pleased to see that Mercer did not include the VUG as a component of its savings calculation in the summary that we received on March 20th. Based on this, MEAHP assumes that DHA Staff will not be pursuing a VUG-based savings claim for Dirigo Year 2, and in that case the Board could disregard this portion of my testimony and the VUG (or "Carrier Initiatives") portion of Mr. Tobin's attached testimony.

Q. Does this conclude your testimony?

A. Yes, it does.

Exhibit Rottkamp 1

NON-CONFIDENTIAL

STATE OF MAINE

DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

BUREAU OF INSURANCE

IN RE:	)	EXHIBIT ___
	)	
REVIEW OF AGGREGATE	)	
MEASURABLE COST SAVINGS	)	PREFILED TESTIMONY OF
DETERMINED BY DIRIGO HEALTH	)	DAVID A. TOBIN, FSA, MAAA,
FOR THE FIRST ASSESSMENT	)	FLMI, ACS, MHP, HIA
YEAR	)	
	)	***October 21, 2005***
Docket No. INS-05-700	)	
	)	

I. Introduction and Overview.

Q. Please state your name and your position and describe your background and qualifications.

A. My name is David A. Tobin and I am employed by CIGNA Healthcare in Bloomfield, Connecticut where I am an Actuarial Senior Director. In this position, I am responsible for nationwide medical pricing of plans for employers with more than 200 subscribers. (This includes those CIGNA plans in Maine that fall into this category.) I hold a Bachelor of Science degree (with High Distinction in Actuarial Science) from the University of Illinois – Champaign and have been employed as an actuary for over twelve years. I am a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries, and a Fellow of the Life Management Institute. I live in Avon, Connecticut.

Q. How did you prepare for your testimony?

A. I have reviewed various materials related to these proceedings including the Mercer Report and the prefiled testimony of Sharon Roberts, Jack C. Keane and Daniel P. McCormack submitted by Anthem Blue Cross/Blue Shield ("Anthem"). I have also reviewed the prefiled testimony filed in this proceeding by John Shiels of the Lewin Group. (Mr. Shiels' testimony is being jointly sponsored by the Maine State Chamber of Commerce and Maine Association of Health Plans ("MEAHP").) I am also specifically familiar with provider cost data and medical cost trends for Maine.

Q. Please indicate the purpose of your testimony.

A. The Dirigo Health Agency ("DHA") is seeking authority to assess CIGNA and other members of the MEAHP with Savings Offset Payments ("SOP") equal to as much as four percent (4%) of our paid claims in Maine. In this testimony, I explain that the savings claimed by DHA are illusory in that (a) they cannot be separated from national and local medical cost trends, and (b) DHA admits that it cannot show that the savings calculation that it has put forward in fact captures only those savings attributable to DHA (if any), as the law appears to require. In addition, I offer my opinion as a healthcare actuary that the methodology used by DHA's consultants of only including data from certain hospitals in the case mix adjusted discharge ("CMAD") calculation is contrary to fundamental actuarial principles. I also testify that factors such as utilization trends and the underwriting cycle could have a greater impact than any conceivable impact resulting from DHA's operations. Finally, I explain that any assessment on Maine's private health insurance carriers under consideration in this proceeding will have to be passed on to our subscribers in the form of higher health insurance premiums. To the degree that the SOP assessment exceeds actual savings, then the likely impact of the Dirigo program will be to increase, not reduce, the number of uninsured Maine citizens—a result precisely contrary to what I understood the Maine Legislature sought to accomplish.

II. Identifying DHA's Impact on Maine Medical Cost Trends.

Q. As an actuary, do you believe that it is possible to objectively determine the impact of the operations of DHA on medical costs in Maine?

A. No, I do not. Total state medical costs are in the billions of dollars and are affected by many economic and regulatory aspects and influences. Among the most significant of the economic influences is the level of general inflation in the economy. This is the prime driver of

wages, expenses and general operating costs incurred by healthcare providers everywhere. Beyond that, the underwriting cycle (which I discuss later in my testimony) can have a greater impact on future costs than anything DHA might accomplish.

Q. Why is this especially significant in this case?

A. Looking at this on a nationwide basis, we see that healthcare cost trends increased steadily from the mid-nineties through the year 2002. After 2002, the national trend decelerated significantly. This is illustrated in Tobin Exhibit 1, which is attached to this Testimony. Tobin Exhibit 1 is a chart prepared by CitiGroup for its 2006 Health Benefits Survey, which was released on October 11, 2005. Any study undertaken for the purpose of identifying the influence of a single factor (here, DHA's operations) on overall healthcare spending would have to carefully control for, and thus take into account, this general trend.

Q. The chart that constitutes Tobin Exhibit 1 also seems to demonstrate that premium yield growth exceeds medical cost growth in some years, tracks it in others, and actually falls below it in some years. Could you comment on this?

A. Yes. The chart nicely illustrates what is widely known in the industry as the "underwriting cycle." In the first phase of the cycle, insurers incur claims in excess of their estimates, causing them to raise premiums. After a period of recoupment, insurers enjoy a period of profitability. In the final phase, insurers begin under-pricing their competitors to capture additional market share, driving premiums down and thus re-starting the cycle. Looking at the chart, we see that premium trends exceeded medical cost trends in the early nineties, but declined steadily, plunging below medical cost trends in 1996, before rising again through 2002. In my opinion, this shows that the underwriting cycle has a profound influence on health insurance premiums.

Q. Did the Mercer Group in fact attempt to distinguish the impact of DHA's operations on Maine healthcare costs versus all other factors?

A. No. In fact, I believe that they determined that this objective was simply not attainable within the constraints resulting from the deadlines in the Dirigo law. I have been furnished with a copy of the Minutes of an August 2 meeting of the Working Group set up by the Maine Legislature in the 2005 amendment to the Dirigo law. This is the Group that was charged with developing a methodology for determining savings generated by DHA's operations, but could not reach agreement. According to these minutes, Mr. Schramm of the Mercer Group made a presentation on the Mercer analysis and then took questions from Working Group members. One Working Group member asked the "$64,000 Question," and Mr. Schramm stated that Mercer made no distinction between DHA-related savings and savings stemming from other sources:

> Q: How does one determine where savings come from?
> Ans: After some review of the savings initiatives to see if the savings are connected to the Dirigo Health Act and after reviewing the Savings Offset Payment process where the actual payment represents only a portion of the savings estimated, Mercer chose an approach that did not separately identify savings associated with the Dirigo Health Act. Mercer indicated that if more data was forthcoming and if time permitted, then a more precise calculation could theoretically be made.

Thus, Mercer appears to have conceded that its analysis did not distinguish DHA-related savings from other factors influencing costs because it could not do so within the time and data constraints presented. Mr. Keane, Anthem's hospital cost consultant, concurs in Mercer's position that no such determination could be made under these constraints, as do I. In fact, as I stated earlier, I believe it would be very difficult to attribute discrete healthcare cost savings to

DHA even if one had unlimited time and ample data. Of course, this is one of the points Mr. Shiels of the Lewin Group makes in his testimony, wherein he outlines a possible procedure that one could pursue to try to establish the actual savings generated by DHA.

Q. Did Mercer in fact take more time and review additional data?

A. I am not aware of any further refinement to the Mercer analysis. Moreover, I question whether any study, no matter how sophisticated, could determine the discrete savings generated by a single source or set of sources. Mr. Schramm stated as much at the August 2 meeting (again, according to the minutes I have reviewed):

> Q: In regard to the CMAD [Case Mix Adjusted Discharge] - Savings are identified as attributable to Dirigo, as are changes in the severity of illness. However, there are quality initiatives developed by carriers and others in the State. How can the changes in severity be attributed to Dirigo only?
> Ans: It is not certain one can differentiate between CMAD changes already in the works versus new initiatives that may have been undertaken during the time period of the baseline. Further, given the timing and the lack of baseline data, it is probably impossible to say whether CMAD improvement is a result of initiatives before 2004 as opposed to 2004 and later.

Here again, Mr. Schramm states that Mercer had neither the time nor the data sufficient to distinguish DHA-related savings from other savings. This is especially significant when one considers that the savings supposedly stemming from the "Hospital Initiatives," which the CMAD technique was supposed to determine, constitute $75 million of DHA's total savings.

Q. Should any savings resulting from the so-called "Hospital Initiatives" be included in the calculation of the SOP?

A. No. As a threshold matter, we have the issue of whether Hospital Initiative savings should be included in the calculation at all. MEAHP's attorneys have advised us that under the law that the Superintendent must apply in this case, the total savings calculation, which establishes one of the caps on the SOP, is supposed to reflect only savings from the reduction of bad debt and charity care caused by the operations of Dirigo, and the savings resulting from an expansion of MaineCare. (MEAHP will be addressing this issue in depth in the Brief that we will file on Monday, October 24.)

Anthem's witness, Jack Keane, also addresses this issue. He agrees that only savings generated by the "operations of Dirigo" or resulting from increased MaineCare enrollment should be included in the SOP calculation. He separately points out that the law does not state that savings accruing from the voluntary cost restraints requested by the Legislature in 2003 should be attributed to DHA.

This issue is one of statutory interpretation and is therefore not within the scope of my testimony.

However, even if the Superintendent decides that the Hospital Initiatives can be included in the overall savings calculation, I agree completely with the point made by Mr. Keane in his testimony that the CMAD measure, as used by DHA in this case, only seeks to measure the degree to which certain hospitals recorded a CMAD that was less than the "expected amount," as determined by DHA. Under DHA's approach, it has attributed 100% of the "delta" between the actual and expected amount to DHA's operations. As Mr. Keane points out, DHA's consultants have made no effort to determine whether any portion of this delta can be "explained," as a statistician would say, by DHA's operations.

In summary, DHA's proposed savings determination is neither *aggregate* (since it excluded a significant portion of the data) nor *measurable* (since it did not statistically verify the savings attributable to DHA's operations).

Q. DHA analysts claim to have measured the impact of DHA's operations through the CMAD measure. Do you agree with the approach they used?

A. No. Obviously, if the Superintendent agrees with MEAHP's and Mr. Keane's view that SOPs should reflect only savings from the reduction of bad debt and charity care (plus the impact of expanded MaineCare enrollment) then this measure cannot be used, since it makes no distinction between savings accruing from one source versus any other.

Even if one were to agree that all hospital cost reductions should be attributed to DHA, however, the Mercer analysis committed a fundamental error that renders their results unusable: as Mr. Shiels and Mr. Keane point out, the DHA study only included data from hospitals where the cost per CMAD beat expectations, while excluding data from hospitals that did not. This, in my opinion, violates a core actuarial principle, since the study reflects only favorable data while excluding unfavorable data. To obtain a reasonable and acceptable study, one would either have to include all data from all of Maine's hospitals or else develop a balanced and unbiased sample of the available data.

Q. Did CIGNA in fact observe any cost reductions from hospitals during the "savings year" currently under review?

A. We noticed a slight easing of cost increases from Maine hospitals during this period. It is not clear that these mild trend reductions were the result of DHA and not a result of some of the other dynamics I previously discussed. If significant DHA-generated savings did in fact occur, the hospitals do not appear to have passed more than a small portion of them on to us. In fact,

our provider contracting staff has heard directly from hospitals that their savings resulting from reduced bad debt and charity care have been largely offset by expansions in MaineCare.

Q. Why would an expansion of MaineCare offset bad debt and charity care cost savings?

A. Because MaineCare does not pay the full cost of the care being provided. This produces the "cost shift" to commercial payors (such as my company) and their subscribers.

In any event, even if the providers actually pass along the entire amount of this minimal cost relief, any benefit that the plans actually get will be totally overwhelmed if the DHA levies an SOP assessment on us.

Our network contracting area has advised that a further slight softening in hospital charges may be coming based on what he has seen in negotiations currently under way, but this would not be reflected in the period under review in this case. (Meanwhile, we have seen minimal softening on the physician side of the equation.)

I would point out that in general, (a) hospital costs tend to be about 50% of our total claims, and (b) a hospital's prices tend to affect about 50% of what hospitals charge us (the other 50% of hospital charges being accounted for in utilization). Using this rule of thumb, one can observe that hospital "prices," or charges, account for only about one-quarter of total costs covered in a given area by a health insurer. This obviously limits the impact one can obtain by urging restraint in hospital charges, as the Maine Legislature did in 2003.

The 50/50 rule of thumb also suggests that better controlling healthcare utilization should be pursued as an approach to controlling total healthcare costs. This could include enhancing disease prevention measures, permitting insurers greater latitude in bargaining with hospitals by relaxing access rules and making healthcare more consumer-driven (unlike the current system in which the insured is almost indifferent to the price of various care options and procedures).

Q. Have the Maine plans themselves taken any steps to address the utilization issue?

A. Yes, we have. Let me offer just one example. My company, CIGNA, has disease management and wellness programs in place that not only improve the health of our subscribers, but result in significant cost savings to our customers. (Attached as Tobin Exhibit 2 is a CIGNA Press Release from last March describing one such program: a weight management and smoking cessation program.) The business logic underlying these programs is very simple: the health insurance company can lower its claims experience, and thus reduce its costs, if it succeeds in improving the health of its members, in turn causing them to reduce hospital utilization. These programs also allow us to compete more effectively in the marketplace.

Q. Does the DHA method of determining savings undermine the incentive for such programs?

A. Very definitely. Under the DHA approach of attributing 100% of determined savings to DHA, any cost savings that a plan's smoking cessation or weight management program might produce will be counted as a DHA-generated cost saving, resulting in an SOP assessment from DHA in a year or two. This would wipe out any gain realized by the health insurance company through member wellness initiatives.

Q. The CMAD measure used by DHA to calculate savings seems to equate hospital expenses with hospital charges. Is this an appropriate assumption?

No. I concur in the point made by Mr. Keane in his testimony that hospital revenues have tended to accelerate faster than hospital expenses, rendering DHA's hospital-expense-based CMAD calculation meaningless for the purpose of determining whether carriers have seen any savings (whether generated by DHA's operations or not). As Mr. Keane states, DHA has

predicated its savings calculation on the assumption that hospital costs and hospital charges have a one-to-one correlation. As Mr. Keane demonstrates, no such correlation exists. CIGNA, Anthem and the other MEAHP members are almost universally on a percentage-of-charge basis with Maine hospitals. In the absence of data demonstrating that hospitals flow through expense savings by adjusting their charges accordingly, any "savings" identified through the CMAD technique should be disregarded.

III. The "Carrier Initiative."

Q. In the 2003 law, the Maine Legislature requested Maine health plans to limit their underwriting gain to 3%. DHA has included $11.2 Million from this initiative as part of its SOP Total. Do you agree with this?

A. No, I do not for several reasons.

First of all, it would not be logical for the Legislature to include this within the pool of savings justifying the assessment to be levied by DHA. Fundamentally, what DHA is saying here is that in Year One a Maine plan set its rates to recover $11.2 Million less than it otherwise would have recovered due to a supposed restraint in underwriting gain. If DHA is now allowed to impose an $11.2 Million SOP assessment in Year Two, then all of the Maine plans will simply have to increase premium in Year Three by $11.2 Million to recover the assessment. Each year's assessment would thus wipe out, dollar-for-dollar, the previous year's "savings", meaning that there would never be any real savings incurred by the Maine healthcare system from this source.

Q. Could the savings from this source be passed along from the providers to the plans in negotiations?

A. No. As I understand it, these "savings" are supposed to take the form of an underwriter deciding to limit its underwriting gain, and therefore charging a lower premium for its health insurance product than it would otherwise charge. This is not a cost saving that a healthcare provider has allegedly realized (which may or may not be passed on to us through lower charges), and it therefore cannot be "wrung out" of the providers in negotiations.

I am also concerned that including the supposed result of underwriting gain restraint in the SOP pool might encourage plans to manipulate the system, with negative consequences.

Q. Could you please explain your concern in this regard?

A. Yes. Keep in mind that a plan can limit its underwriting gain by a variety of means. For example, assume Plan A incurs substantial costs in Year One in launching a new product or service. Keeping all else equal, this would tend to depress Plan A's underwriting gain for Year One. To dramatize the impact of this, let us assume that but for the cost of its new product launch, Plan A's underwriting gain would have been 5%. Now let's assume that the other Maine plans did not restrain their underwriting gains in Year One, but that the costs of Plan A's product launch, which drove its underwriting gain from 5% to, say, 1.5%, produced Year One "savings," as determined by the DHA/Mercer approach, of $10 Million. Under DHA's methodology, we exclude the data from the non-restraining plans and look only at the data from Plan A, which shows a gain of less than 3% (again, due to the costs associated with its new venture). The $10 Million SOP assessment levied by DHA in Year Two based on Plan A's savings would fall on all plans in proportion to their respective shares of paid claims in the Maine market. Thus, the result in this example would be to force all of the Maine plans to subsidize a portion of Plan A's

product launch costs. To follow this along to its ultimate result, in Year Three, when Plan A and the other Plans pass this assessment along to their members in the form of an increase in insurance premium (because, as I mentioned before, there is no argument that a plan could wring the savings derived from restraining underwriting gain from hospitals or other providers), the members of all of Maine's health plans would end up subsidizing Plan A's product launch via the SOP assessment.

By the way, a plan might also limit its underwriting gain (and lower its prices) simply to obtain additional market share by underpricing its competitors. Under DHA's approach, the resulting "savings" would be included in next year's SOP assessment, thus forcing the underpricing plan's competitors (and, ultimately, their members) to shoulder a portion of the cost incurred by the undercutting plan of obtaining the additional market share.

As this shows, DHA's attempt to levy an SOP made up, in part, of supposed savings resulting from underwriting gain restraint makes no sense and in fact could encourage conduct that would be very harmful to consumers.

IV. Negative Effect of an SOP.

Q. Maine law provides that health plans will be able to pass the SOP along to their members in the form of higher insurance rates. Since consumers will be paying for this, why is MEAHP so concerned with the SOP level?

A. As with any other product, as one increases the price of the product (for any reason, including the imposition of new taxes), the market shrinks. Imposition of an SOP assessment would require CIGNA and the other members of MEAHP to increase the price of our products to a higher level than would have been the case in the absence of the assessment. This will probably result in some further shrinkage of the private health insurance market in Maine,

making the "pie" smaller for all competitors in the market. Quite simply, this is bad for our business and bad for Maine consumers

Q. Can you quantify the number of Maine people who will lose their health insurance as a result of an SOP assessment?

A. No. However, I am generally familiar with, and consider reliable, the studies underlying Anthem witness Sharon Roberts' estimate that a 1% increase in the price of health insurance results in 300,000 Americans losing their coverage. I have also reviewed Mr. Shiels' testimony on this subject and I consider his assessment to be reasonable.

Whatever the relevant factor of price versus lost coverage might be for Maine, there can be no question that a number of Mainers will lose coverage if the SOP assessment is imposed. Nationwide the number of uninsured continue to rise and employers continue to lower their contribution amount for premium. An additional assessment increase (especially without offsetting actual savings) will further exacerbate this problem.

V. Conclusion.

Q. Do you have any concluding remarks?

A. DHA's experts have admitted that DHA's savings calculation was not based on a measurement of savings generated by DHA's operations. For that reason alone, I recommend that the Superintendent find that DHA has not proven any "aggregate measurable savings" in this case.

If DHA's savings calculation is approved, it will pave the way to an increase in Maine health insurance rates. The resulting increase will cause some number of Maine people to lose health insurance despite the fact that Mercer has admitted that its SOP calculation was not based

on measured savings actually generated by DHA. This cannot be the result that the Maine Legislature intended when it launched DHA.

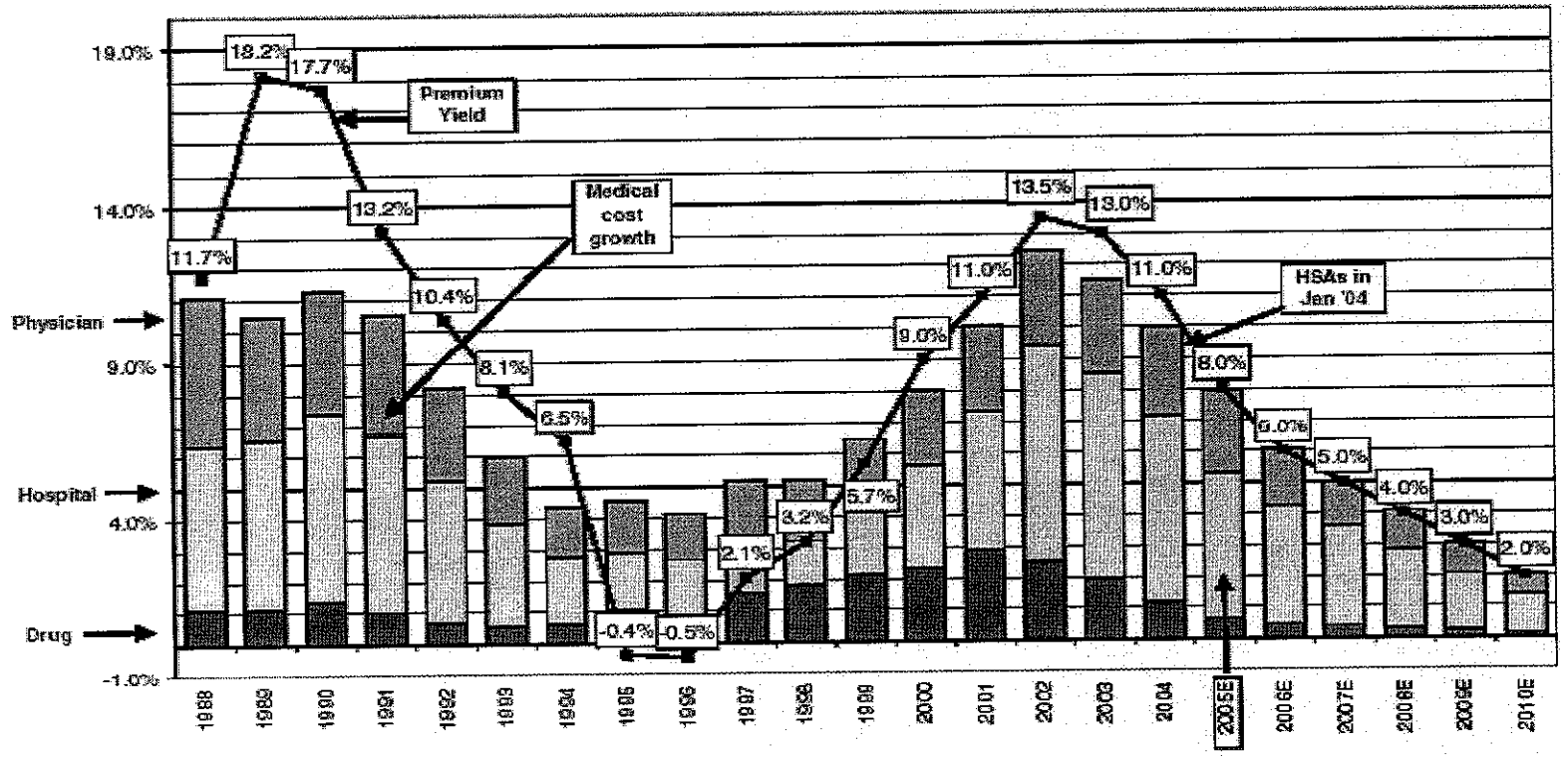
Q. Does this conclude your testimony?

A. Yes, it does.

TOBIN EXHIBIT 1

Figure 1. 1988–2010 Premium vs. Cost Increases — Our Modeling Assumptions

year-over-year % change



Source: 1988–2004 data from CMS, Milliman USA, AAHP, KPMG; 2005–10E from Citigroup Investment Research

Tobin Exhibit 2

Press Release Source: CIGNA HealthCare

CIGNA's Healthy Rewards(R) Program Expands Weight Management and Tobacco Cessation Offerings

Thursday March 18, 9:04 am ET

New Programs Address Leading Causes of Preventable Deaths and High Medical Costs

BLOOMFIELD, Conn., March 18, 2004 /PRNewswire-FirstCall/ -- Tobacco use and obesity rank as the leading causes of preventable death in the United States, killing nearly 435,000 and 400,000 Americans respectively in 2000(1). They also contribute to higher medical costs. In fact, studies show the annual medical claims are 27 percent higher for employees who smoke and 36 percent higher for those who are obese compared to their non-smoking and non- obese counterparts(2).

To help address these concerns, CIGNA HealthCare recently expanded the weight management and tobacco cessation offerings available to members through its Healthy Rewards® health and wellness discount amenities program, where members can receive up to 60 percent off the retail price for a myriad of products and services.*

Through an agreement with Weight Watchers North America Inc., CIGNA is the first health insurance carrier to offer discounts for Weight Watchers' three different programs nationwide.

The company also signed an agreement for Tobacco Solutions, an eight-week tobacco cessation program offering deep discounts on the Novartis Habitrol Transdermal system, "the patch," and behavioral support through educational materials and toll-free counseling support five days a week.

Through another arrangement, CIGNA members can receive a discounted lifetime subscription rate to QuitNet®, an online smoking cessation program and community available 24 hours a day with access to support, counseling and education to help them quit smoking and remain tobacco-free.

"CIGNA Healthy Rewards® works hand in glove with employers' corporate preventive health and wellness programs," said Diana Wynne, project manager for CIGNA's Healthy Rewards® program. "More and more, employers recognize that investing in promoting wellness can reap big returns. Through Healthy Rewards®, the employer can save and so can the employee."

In fact, some large U.S. corporations have estimated an average return of $5 for every dollar invested in wellness programs and an average 2.5 percent drop in healthcare costs(3).

Healthy Rewards® offers discounts on a variety of programs that emphasize weight management, nutrition, fitness and healthy lifestyle choices, as well as savings on other products and services consumers use every day.

From Jan. 1, 2001 to June 30, 2003, more than 50,000 CIGNA members have saved $5.6 million through Healthy Rewards® on fitness club memberships, herbal and nutrition supplements, over-the-counter health and beauty products, vision and hearing care services, and laser vision care.

Wynne said the actual savings and member participation in Healthy Rewards® are even higher than these statistics suggest. "One consumer benefit of the program is that there is no paperwork or referral. So, data on some of the offerings like discounts on massage therapy, chiropractic care, acupuncture and cosmetic dentistry are more difficult to track."

Through the latest Healthy Rewards® offerings, CIGNA members can receive the following savings:

-- Weight Watchers(R) Traditional Meetings - Free registration at group meetings. A $15-28 savings depending on location.*
-- Weight Watchers Online - $10 discount on the 3-month subscription for online access to personalized weight management tools, information and resources. The retail price is $59.95 and is available to CIGNA members for $49.95.
-- Weight Watchers At Home - $10 off the retail price ($99.95 plus shipping and handling) of at-home kit in participating areas. Members pay $89.95 plus shipping and handling.
-- Tobacco Solutions - Over 50 percent off the $281 retail price. CIGNA members pay $135, which includes eight weeks of the Habitrol patch. At $4 for a pack of cigarettes, that's less than half the cost the average pack-a-day smoker would spend over the same period.
-- QuitNet(R) - Members receive a special lifetime subscription rate of $65, a 35 percent discount off the annual membership price of $99.

NEWS RELEASE

CIGNA HealthCare

EMBARGOED FOR RELEASE, February 2, 2006, 9:30 a.m.

CONTACT: Amy Turkington, 860.226.3489

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CIGNA Choice Fund[SM] Study Provides New Insights on Consumer Decision-making in Consumer-Driven Health Plans

Bloomfield, Conn. - February 2, 2006 - A CIGNA HealthCare analysis of 42,200 first-time users of consumer-driven health plans found these consumers generated an eight percent reduction in medical costs and made positive changes in health behavior, such as increasing their use of medications to treat chronic health care conditions.

"These study results show that given greater choice and control, the right incentives and actionable decision support, CIGNA Choice Fund members are becoming more involved in their health care and health care decision-making, while not compromising needed care," said Michael Showalter, vice president of consumerism for CIGNA HealthCare.

CIGNA's national study is one of the largest and most comprehensive analyses of consumer-driven health plans conducted to date. The medical claims study included two separate analyses: the first comparing the claims experience of 42,200 continuously enrolled members before and after

their switch in 2005 from a traditional HMO or PPO plan to one of CIGNA HealthCare's HRA or HSA plans, and the other comparing this group's health care costs and utilization patterns to a control group of 140,200 members enrolled in a traditional HMO or PPO plan from the same employer groups' populations.

Managing Medical Costs

Total medical costs excluding prescription drug expenses for those enrolled in a CIGNA Choice Fund plan declined by approximately eight percent compared to the prior period, while costs for those enrolled in a traditional HMO or PPO plan increased by approximately four percent.

Changes in health care spending were driven by a reduction in both inpatient and outpatient facility costs, which declined approximately five percent and 12 percent respectively, when compared to the prior period. Inpatient and outpatient facility costs for CIGNA Choice Fund enrollees were also lower when compared to costs for the control group who were enrolled in a traditional plan. Importantly, while overall costs decreased for these services, the actual number of admissions increased compared to the prior period, showing that consumers received needed care in cost-effective ways.

The study released today is also one of the first to provide early data comparing cost among groups of consumers who had similar levels of claims in the prior period --- classified in the study as low, medium or

heavy users of health care services -- to examine changes in decision-making after enrollment in a consumer-driven health plan.

The analysis showed that cost savings were observed across all categories, with the most pronounced savings occurring among medium and heavy users of care - those with medical (non-pharmacy) claims of $1,000-$8,000 and in excess of $8,000.

"This early data suggests that the change in health care decision-making encouraged by a consumer-driven plan doesn't end once a consumer satisfies the deductible or reaches the out-of-pocket maximum," Showalter said. "It also signals that health advocacy programs like health coaching, along with access to information tools and consumer advisors, are essential components of a consumer-driven health plan," Showalter said, noting that the goal of these programs is to help members improve their health, which, in turn, controls costs.

Improving Medication Compliance

The study indicated that when compared to the prior period, CIGNA Choice Fund members who had prescription drug coverage through CIGNA HealthCare significantly increased their usage of medications used to control diabetes (+18%), asthma (+8%), high cholesterol (+23%) and to prevent heart attacks (+18%). They were more discerning in their use of some types of prescription medications for which alternatives are available over-the-counter, such as medications for migraines (-4%) and anti-ulcer drugs (-7%).

Notably, the total days supply of prescription drugs obtained by CIGNA Choice Fund members increased compared to the prior period, but the cost per day for the medications decreased, suggesting that CIGNA Choice Fund members did not skip medications but instead made more cost-effective decisions.

"CIGNA Choice Fund members appear to be taking advantage of the many decision support resources available, such as CIGNA's pharmacy-specific online price quote tool, to make more cost-effective decisions," Showalter said. "But in this process, they are improving their compliance with medication therapy, which helps lead to better health and reduced costs for other types of services."

Costs for prescription drugs for CIGNA Choice Fund members, while increasing compared to the prior period, were five percent less than the costs for the control group of members enrolled in a traditional plan.

About the Study

The study included two separate analyses. First, it examined the claims experience of 42,200 continuously enrolled members who switched from a traditional HMO or PPO plan to one of CIGNA HealthCare's HRA or HSA plans in 2005. The analysis compared this group's claims for the six-month period January 2005 to June 2005 to their claims from the same period in 2004. To examine pharmacy costs and utilization, the study reviewed the claims experience of 29,577 CIGNA Choice Fund members who also had pharmacy coverage through CIGNA HealthCare.

In addition, the study also compared this group's health care costs and utilization patterns to those of 140,200 members enrolled in a traditional HMO or PPO plan from the same employer groups' populations during the same January-June 2005 time period. To examine pharmacy costs and utilization, the study reviewed the claims experience of 130,550 members enrolled in traditional plans who also had pharmacy coverage through CIGNA HealthCare.

The study drew upon data from 44 different employer groups offering CIGNA HealthCare's consumer-driven health care plans to employees. Total medical cost as used in the study represents overall medical (non-pharmacy) costs for both consumers and employers. Costs for catastrophic claims totaling more than $50,000 in either period for all populations were excluded from the analysis to reduce random variation and improve the reliability of the results.

About CIGNA HealthCare

CIGNA HealthCare, headquartered in Bloomfield, CT, provides medical benefits plans, dental coverage, behavioral health coverage, pharmacy benefits and products and services that integrate and analyze information to support consumerism and health advocacy. "CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation (NYSE:CI). Products and services are provided by these operating subsidiaries and not by CIGNA Corporation.

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